

TUCSON WOMEN'S CENTER

MEDICAL WEIGHT LOSS PROGRAM INTAKE

Name: _____

Date of Birth: _____

WEIGHT LOSS GOALS

1. What made you decide to make a change now?
2. Are there specific areas of your body that you would like to change?
3. Are you on a timeline (e.g. before the wedding, cruise, reunion)?
4. Do you have target values (e.g. goal weight, % body fat, BMI)?

WEIGHT HISTORY

5. Have you been over weight in the past?

	Yes	No
Child		
Adolescent		
Adult		

CURRENT DIET

6. What type of foods do you eat in an average day?

	Week day	Week end
Breakfast/snack		
Lunch/snack		
Dinner/ snack		

7. On a scale from 1-6 are you more likely to prepare your meals or eat out?

Eat in-----1-----2-----3-----4-----5-----6 Eat out

DIETING HISTORY

Type of diet	How long did you try it?	How much did you lose?	Why did you stop?

8. Do you have a history of eating disorders? Please describe.

9. Do you exercise? If so how often and for how long?

PAST MEDICAL HISTORY

i. Please check all that apply

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	History of Asthma	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	Breast lump or tumor	<input type="checkbox"/>	Blood clots in legs	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	STI	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	Bladder infection
<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Sickle cell anemia
<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	Pelvic infection	<input type="checkbox"/>	Hepatitis

ii. Please check all that apply

Depression Addiction (describe) Eating disorder (describe)

iii. List medications that you are currently taking

iv. List drug allergies and sensitivities

- v. List previous surgeries

FAMILY HISTORY

	Hypertension	Heart disease	Diabetes	High cholesterol
Mother				
Father				
Siblings				

SOCIAL HISTORY

10. Do you have friends/family supporting you in your weight loss effort?
11. Do you smoke? Yes ___ No ___
12. Do you use any type of recreational drugs? Please list
13. How many alcohol containing drinks do you have per week?

Tucson Women's Center Weight Loss Program Consent Form

I _____ authorize Dr. _____ and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____

Time: _____

Witness: _____

Patient: _____

(Or person with authority to consent for patient)

TUCSON WOMEN'S CENTER

Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request.

I have read the above:

Patient's Signature

Date

Tucson Women's Center

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I, _____ (patient or patient's guardian) authorize Dr. _____ to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

“Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

“As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

“Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

“As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give.”

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness,

psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ **TIME:** _____

PATIENT: _____ **WITNESS:** _____

(or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's Signature